

Community Care of North Carolina/Carolina ACCESS (CCNC/CA)

CCNC/CA PCCM model was established in 1991 based on the premise that patient care is best served by a medical home where a Primary Care Provider (PCP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

Attention Recipient: Please fill out this section of the form consisting of enrollee's name, **Medicaid/NCHC ID#**, DOB and county of residence

(Enrollee's Name of Residence)	(Medicaid/NCHC ID#)	(DOB)	(County)
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Attention Physician: This section is to be completed only by the physician. Check all blocks that apply; however, at least one block must be checked. Mail form and pertinent medical records to the address below.

- ☐ **Terminal illness** (the enrollee has a six (6) month or less life expectancy and/or is currently a hospice patient.)

☐ **Chemotherapy or Radiation treatments** currently being administered. (**Note:** Exemptions for this purpose are temporary until the completion of the therapy. If the therapy will last longer than 6 months, exemption must be requested after the 6 month time period during reapplication for Medicaid coverage.)

☐ ***Impaired mental/cognitive status** that makes it impossible for the adult recipient to comprehend and participate in **CCNC/CA**. (**Note:** This statement is not a determination of the patient's legal mental competence.)

☐ ***Diagnosis/Other information:** (Specify reasons why this recipient would not benefit from having a medical home with a local PCP who would coordinate their care and the recipient's medical record)

***MEDICAL RECORDS REQUIRED**

Pursuant to federal regulations regarding utilization of Medicaid services, the Division of Medical Assistance is authorized by Section 1902 (a) (27) of the Social Security Act and Federal Regulation 42 CFR 431.107 to access information from the patient's medical records for the purposes directly related to the administration of the Medicaid Program. Therefore, no special enrollee permission is necessary for the release of medical records. In addition, when applying for Medicaid benefits, each enrollee signs a release, which authorizes access to his/her Medicaid records by the appropriate authorities.

(Physician Signature) (Provider No.) (Date)

(Print Physician Name) (Telephone Number)

If you have any questions or would like to apply to become a **CCNC/CA** provider, please contact DMA/Managed Care at (919) **855-4780**.

Mail completed signed forms to: DMA/ Managed Care
2501 Mail Service Center
Raleigh, NC 27699-2501